

Patient Data

Patient Name: _____ Birthdate: _____ Sex: Male Female Height: _____ Weight: _____ lbs kg
 SSN #: XXX-XX-____ Known Allergies: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Cell Phone: _____ Primary Language: _____
 Authorized Contact: _____ Contact's Phone: _____

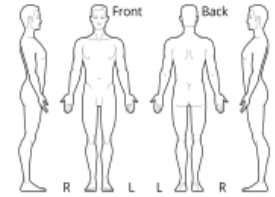
Ins. Data

Primary Insurance: _____ Secondary Insurance: _____
 ID: _____ Group#: _____ ID: _____ Group#: _____

Clinical Information

To expedite prior authorization, please attach PPD results, lab results, clinical office notes, and past treatment history.

Diagnosis: _____ ICD 10 code: _____ Date of Diagnosis (or years with disease): _____
 Severity: Moderate Moderate to Severe Severe Dose patient have a latex allergy? Yes No _____ % BSA affected by Psoriasis
 Has patient received PPD (tuberculosis) skin test? Yes No Date: _____ Results: Positive Negative
 Has patient been tested for Hepatitis B? Yes No If positive, has treatment been initiated? Yes No
 Has patient previously been treated for this condition? Yes No Injection Training Needed? Yes No
 If yes, medication/therapy failed (length of therapy): _____



Prescription

Medication	Strength	Directions	Quantity	Refills
<input type="checkbox"/> Orencia	<input type="checkbox"/> 125mg/ml ClickJect™ Autoinjector <input type="checkbox"/> 125mg/ml PFS	Inject 125mg SQ once weekly	#4	
<input type="checkbox"/> Otezla®	<input type="checkbox"/> Titration Starter Pack	Day 1: 10mg in the morning Day 2: 10mg in the morning and in the evening Day 3: 10mg in the morning and 20mg in the evening Day 4: 20mg in the morning and in the evening Day 5: 20mg in the morning and 30mg in the evening Day 6 and thereafter: 30mg twice daily	1 pack	0 refills
	<input type="checkbox"/> 30mg tablet	<input type="checkbox"/> Maintenance: 30mg twice daily	#60	
<input type="checkbox"/> Siliq™	210mg PFS	<input type="checkbox"/> Induction: Inject 210mg SQ at weeks 0, 1, and 2	#3 syringes	0 refills
		<input type="checkbox"/> Maintenance: Inject 210mg SQ once every 2 weeks	#2 syringes	
<input type="checkbox"/> Simponi®	<input type="checkbox"/> 50mg/0.5ml SmartJect™ Autoinjector <input type="checkbox"/> 50mg/0.5ml PFS	Inject 50mg SQ once monthly	#1	
<input type="checkbox"/> Skyrizi™	75mg/0.83ml PFS	<input type="checkbox"/> Induction: Inject 150mg (2 injections) SQ at weeks 0 and 4	#4 syringes	0 refills
		<input type="checkbox"/> Maintenance: Inject 150mg (2 injections) SQ every 12 weeks	#2 syringes	
<input type="checkbox"/> Stelara®	<input type="checkbox"/> 45mg/0.5ml PFS (<100kg)	<input type="checkbox"/> Induction: Inject 45mg SQ at days 0 and 28 <input type="checkbox"/> Maintenance: Inject 45mg SQ every 12 weeks	#2 syringes	0 refills
	<input type="checkbox"/> 90mg/ml PFS (>100kg)	<input type="checkbox"/> Induction: Inject 90mg SQ at days 0 and 28 <input type="checkbox"/> Maintenance: Inject 90mg SQ every 12 weeks	#2 syringes	0 refills
<input type="checkbox"/> Taltz®	<input type="checkbox"/> 80mg/ml Autoinjector	<input type="checkbox"/> Induction: Inject 160mg (2 injections) SQ at week 0, then inject 80mg (1 injection) at weeks 2, 4, 6, 8, 10, and 12	#8	0 refills
	<input type="checkbox"/> 80mg/ml PFS	<input type="checkbox"/> Maintenance: Injection 80mg SQ once every 4 weeks	#1	
<input type="checkbox"/> Tremfya®	100mg/ml PFS	<input type="checkbox"/> Induction: Inject 100mg SQ at weeks 0 and 4	#2	0 refills
		<input type="checkbox"/> Maintenance: Inject 100mg SQ every 8 weeks	#1	
<input type="checkbox"/> Xeljanz®	5mg tablet	Take 1 tablet orally twice daily	#60	
<input type="checkbox"/> Xeljanz® XR	11mg tablet	Take 1 tablet orally once daily	#30	

Is patient new to this therapy: YES NO | Ship to: Patient Office Other | Desired Start Date: _____

Prescriber Data

Prescriber Name: _____ DEA#: _____ NPI: _____
 Practice Name: _____ Contact: _____
 Address: _____ Phone: _____ Fax: _____
 City: _____ State: _____ Zip: _____ Key Contact#: _____

My signature below authorizes Value Specialty Pharmacy staff to act as my authorized agent to complete the insurance prior authorization process for my patient listed above. My authorization shall include any required signatures by Value Specialty Pharmacists on my behalf to facilitate this process and acknowledge their authorized access to necessary healthcare data to complete said process.

Physician Signature: _____ Date: _____ This prescription will be filled generically unless prescriber writes "DAW" in the box to the right.